SERFF Tracking Number:	*LBLI-128190021*	*State:*	*Arkansas*
Filing Company:	*Athene Annuity & Life Assurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CFA3001PCR(02-12)*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CFA3001PCR(02-12)*		
Project Name/Number:	*CFA3001PCR(02-12)/CFA3001PCR(02-12)*		

Filing at a Glance

Company: Athene Annuity & Life Assurance Company

Product Name: CFA3001PCR(02-12)	SERFF Tr Num: LBLI-128190021	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L08.000 Life - Other	Co Tr Num: CFA3001PCR(02-12)	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Holly Carver, Dianne Harris	Disposition Date: 03/28/2012
	Date Submitted: 03/23/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: CFA3001PCR(02-12)	Status of Filing in Domicile: Pending
Project Number: CFA3001PCR(02-12)	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filed simultaneously with this filing.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 03/28/2012
	State Status Changed: 03/28/2012
Deemer Date:	Created By: Dianne Harris
Submitted By: Dianne Harris	Corresponding Filing Tracking Number:

Filing Description:

RE: Form Number CFA3001PCR(02-12), Application for Policy Change or Reinstatement
Athene Annuity & Life Assurance Company, NAIC Co. No. 61492, Group 0000, FEIN 44-0188050

The above referenced form is being submitted for your review and approval. The form will be used if an insured/owner wishes to make changes to existing insurance coverage or to reinstate lapsed coverage. The form will be used with previously approved products. The form was previously submitted and approved via SERFF #LBLI-126683916, on 6/30/2010. The only change to this form, other than the updated form number is the addition of a statement regarding implications of a Modified Endowment Contract and recently required updates to the MIB section. Please find attached

SERFF Tracking Number:	*LBLI-128190021*	*State:*	*Arkansas*
Filing Company:	*Athene Annuity & Life Assurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CFA3001PCR(02-12)*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CFA3001PCR(02-12)*		
Project Name/Number:	*CFA3001PCR(02-12)/CFA3001PCR(02-12)*		

version completed in John Doe fashion. This form will be used in a paper environment.

Thank you in advance for your review. To the best of my knowledge and belief, this form complies with the statutory and regulatory requirements of your state. This form contains no unusual or possible controversial items from normal company or industry standards. If you have questions or need additional information, please contact me at 864-609-1198 or by email at dharris@athene.com.

Company and Contact

Filing Contact Information

Dianne Harris, Compliance Analyst	dianne.harris@atheneannuity.com
2000 Wade Hampton Blvd	864-609-1198 [Phone]
Greenville, SC 29615	864-609-1039 [FAX]

Filing Company Information

Athene Annuity & Life Assurance Company	CoCode: 61492	State of Domicile: Delaware
2000 Wade Hampton Blvd	Group Code:	Company Type:
Greenville, SC 29602	Group Name:	State ID Number:
(864) 609-1334 ext. [Phone]	FEIN Number: 44-0188050	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	AR charges $50/form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Athene Annuity & Life Assurance Company	$50.00	03/23/2012	57407517

SERFF Tracking Number:	*LBLI-128190021*	*State:*	*Arkansas*
Filing Company:	*Athene Annuity & Life Assurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CFA3001PCR(02-12)*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CFA3001PCR(02-12)*		
Project Name/Number:	*CFA3001PCR(02-12)/CFA3001PCR(02-12)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/28/2012	03/28/2012

SERFF Tracking Number:	*LBLI-128190021*	*State:*	*Arkansas*
Filing Company:	*Athene Annuity & Life Assurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CFA3001PCR(02-12)*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CFA3001PCR(02-12)*		
Project Name/Number:	*CFA3001PCR(02-12)/CFA3001PCR(02-12)*		

Disposition

Disposition Date: 03/28/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LBLI-128190021*	*State:*	*Arkansas*
Filing Company:	*Athene Annuity & Life Assurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CFA3001PCR(02-12)*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CFA3001PCR(02-12)*		
Project Name/Number:	*CFA3001PCR(02-12)/CFA3001PCR(02-12)*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Application for Policy Change or Reinstatement		Yes

SERFF Tracking Number:	*LBLI-128190021*	*State:*	*Arkansas*
Filing Company:	*Athene Annuity & Life Assurance Company*	*State Tracking Number:*	
Company Tracking Number:	*CFA3001PCR(02-12)*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CFA3001PCR(02-12)*		
Project Name/Number:	*CFA3001PCR(02-12)/CFA3001PCR(02-12)*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	CFA3001PCR(02-12)	Application/ Enrollment Form	Application for Policy Change or Reinstatement	Initial		51.500	CFA3001PCR (02-12) MIB - Doe.pdf

ATHENE

APPLICATION FOR POLICY CHANGE OR REINSTATEMENT

[ATHENE ANNUITY & LIFE ASSURANCE COMPANY], [Wilmington, Delaware]
[Main Administrative Office: 2000 Wade Hampton Blvd. Greenville, SC 29615-1064]

General Instructions For Using This Form

*SUBMIT ONE FORM for each policy to be changed or reinstated. A separate Application for Insurance Part II must also be completed for each applicant except as noted below for Tobacco Class change for Express*TERM.

☐	Reinstatement.	Complete all of Section I, Section II.A., Section III, and the Application for Insurance Part II.
☑	Face Amount Changes.	Complete all of Section I, Section II.B., Section III, and the Application for Insurance Part II. Please consult your policy or product guide to determine the type of changes that can be requested, limitations may apply.
☐	Benefit And Rider Changes.	Complete all of Section I, Section II.C., Section III, and the Application for Insurance Part II. Please consult your policy or product guide to determine the type of changes that can be requested, limitations may apply.
☐	Tobacco Class Change.	Complete all of Section I, Section II.D., Tobacco Questionnaire and the Application for Insurance Part II. Agent collected saliva or a urinalysis is required for face amounts at $100,000 and above, excluding ExpressTERM.
☐	Rate Reduction.	Complete all of Section I, Section II. E., Section III, and the Application for Insurance Part II.

Section I: Policy and Insured Information.

Policy Number AB12345

Insured's Name (*Print First, Middle, Last*) John Q. Doe ☑ Male ☐ Female

Date of Birth 01 / 01 / 1959 State of Birth SC Marital Status: ☐ Married ☑ Single ☐ Separated ☐ Divorced ☐ Widowed

Height *(ft/in)* 6' 0" Weight *(lbs)* 180 SSN/Tax ID 123-45-6789 E-mail John.Doe@yahoo.com

Residence Address *(No PO Box)* 123 Any Street Mailing Address *(if different)* _____

City Anywhere State SC Zip 12345 City _____ State _____ Zip _____

Phone: Day (888) 111-1111 Evening (888) 222-2222 Best time to call: After 5:00 pm

Do you have a driver's license? ☑ Yes License Number 0123456 State of Issue SC

☐ No If No, provide details _____

Are you employed? ☑ Yes Occupation/Duties Nurse Annual Income $ 100,000

☐ No If No, provide details _____ Household Income $ _____

Have you ever used any tobacco or nicotine products? ☐ Yes ☑ No

If Yes, when did you last use tobacco or nicotine products *(mm/yyyy)* _____ Type _____ Quantity _____

Policyowner Information *(complete only if different than insured)*

Owner's Name *(Print First, Middle, Last)* _____

Residence *(No PO Box)* _____ Mailing Address *(if different)* _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Daytime Phone (____)_____ Evening (____)_____ E-mail _____

Relationship to Insured _____

Section II.

A. Reinstate *(Please indicate premium amount below and complete Application for Insurance Part II)*

Enclosed is $ _____ premium due.

B. Face Amount Change *(If increasing Face Amount please complete Section III of this form and Application for Insurance Part II)*

☑ Increase Base Policy by $ 50,000 for a total face amount of $ 100,000

☐ Decrease* Base Policy by $ _____ for a total face amount of $ _____

☐ Decrease*_____Rider by $ _____ for a total face amount of $ _____

* Ultimate Face Amount must meet the minimum face amount requirements for your plan or product.

C. Benefit and Rider Changes

(Please complete Section III of this form and Application for Insurance Part II if adding or increasing a benefit or rider. Please complete an Application for Insurance Part II on each proposed insured being added)

Accident Only Disability Benefit ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Accidental Death Benefit ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Critical Illness Benefit ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Disability Income Benefit ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Term Rider ☐ Decreasing ☐ Level _____yr. ☐ Add ☐ Delete ☐ Decrease Benefit Amount $_____

Children's Insurance Benefit Rider ☐ Add ☐ Delete Benefit Amount $_____

Waiver of Premium or Waiver of Monthly Deduction ☐ Add ☐ Delete

Death Benefit Option Change From _____ To _____

Other _____ Benefit Amount $_____

Other Insured Rider *(complete information below if adding)* ☐ Add ☐ Delete Benefit Amount $_____

Proposed Insured's Name *(Print First, Middle, Last)* _____ ☐ Male ☐ Female

Relationship to Primary Insured _____

Date of Birth _____/_____/_____ State of Birth_____Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Height *(ft/in)*_____ Weight *(lbs)*_____ SSN/Tax ID_____ E-mail _____

Residence Address *(No PO Box)* _____ Mailing Address *(if different)* _____

City _____ State_____ Zip _____ City _____ State _____ Zip _____

Phone: Day (____)_____ Evening (____) _____ Best time to call: ☐ 8am – Noon ☐ Noon – 5pm ☐ 5pm – 9pm

Do you have a driver's license? ☐ Yes License Number _____ State of Issue _____

☐ No If No, provide details _____

Are you employed? ☐ Yes Occupation/Duties _____ Annual Income $ _____

☐ No If No, provide details _____ Household Income $_____

Have you ever used any tobacco or nicotine products? ☐ Yes ☐ No

If Yes, when did you last use tobacco or nicotine products *(mm/yyyy)* _____ Type _____ Quantity _____

D. Tobacco Class Change (*Please complete Application for Insurance Part II and the Tobacco Questionnaire)*

☐ Change to Non-Tobacco

E. Rate Reduction (*Please complete Application for Insurance Part II)*

☐ Reduce or Remove substandard rating

Section III.

1. In the past five years, have you:	Yes	No	Provide complete details to any Yes answers
A. Been charged with DUI/DWI, had two or more moving violations, had an accident, or had your driver's license suspended or revoked?	☐	☐	
B. Flown as a pilot, student pilot or crew member of any aircraft or have any intentions to do so?	☐	☐	
C. Engaged in parachuting, skydiving, scuba diving below 50 feet, racing of any motor powered land vehicle or watercraft, or any other hazardous activities or extreme sports or have any intention to do so within the next two years?	☐	☐	
2. Have you ever been arrested for, convicted of, or pled guilty or no contest to any felony, misdemeanor, or to possession or distribution of drugs or other illegal substance?	☐	☐	

Authorizations, Declarations & Signatures.

Authorization to Obtain and Disclose Information - I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care provider, pharmacy benefit manager, insurance company or reinsurer, government agency, MIB, Inc., formerly known as the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, employer or other organization, institution or person to disclose to the insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers of Athene Annuity & Life Assurance Company (the "Company"), the following information pertaining to me or any of my minor children proposed for coverage: (1) employment information; (2) other insurance coverage; (3) prescribed drugs; (4) past and present physical, mental, drug and/or alcohol conditions; (5) motor vehicle records; (6) avocations; (7) general reputation; and (8) other personal characteristics. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I understand and agree to the following:
The Company may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits. The Company may disclose all or some of my information to its insurance administrators, its reinsurance companies, its agents, MIB, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months. A photographic copy of this authorization is as valid as the original and I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation may cause the Company to reject my application.

Acknowledgement - By signing below, each person applying for coverage understands, represents, and agrees to the following: I have read this application and the statements and answers made in this application are true and complete to the best of my knowledge and belief and are made to obtain the insurance applied for. I understand that the insurance I applied for will take effect only if the Company accepts this application and issues the requested change or reinstatement and if, on the date of issue: (1) the required premium for the change or reinstatement has been paid; (2) the proposed insured is alive, and (3) all conditions used to determine the proposed insured's insurability remain as stated in the application. No agent or person other than the Company's Home Office officers has the authority to change or modify this application or the policy applied for.

I (We) also understand that under current tax law, the policy changes requested and/or subsequent policy changes may cause the policy to be a Modified Endowment Contract, which could include taxation of any loans, withdrawals, or surrenders in excess of the amount of premiums paid into the policy.

Certain state insurance departments require that we advise you of the following statements:

For residents of Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

All completed materials must be sent to Athene Annuity & Life Assurance Company, PO Box 789, Greenville SC 29602-1389

Signed on June 1, 2012
Date

X Signature of Insured *John Q. Doe*

X Signature of Proposed Other Insured _____

X Signature of Policy Owner _____

Section IV: For Agent Use, if applicable.

X Signature of Writing Agent *Athene Annuity Agent* Date June 1, 2012

Printed Name of Writing Agent Athene Annuity Agent

Agent Information

Name	Agency/Broker Dealer Name	Agent Code	Commission Split

Contact Information

Status updates and requests for additional information should be sent to:

☐ Agent _____ E-mail _____

☐ Name _____ E-mail _____

Special Instructions

SERFF Tracking Number:	*LBLI-128190021*	*State:*	*Arkansas*
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TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*CFA3001PCR(02-12)*		
Project Name/Number:	*CFA3001PCR(02-12)/CFA3001PCR(02-12)*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Generic App for Policy Change or Reinstatement READABILITY COMPLIANCE CERTIFICATION.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: N/A - Application Filing
Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
Generic Statement of Variability.pdf

READABILITY COMPLIANCE CERTIFICATION

1. Insurer: Liberty Life Insurance Company
PO Box 789
Greenville, South Carolina 29602-0789

2. Certification: I hereby certify that the forms listed below produce Flesch reading ease scores which meet the minimum score required in your state.

In addition, I certify that the forms, except for schedules and tables, are printed in 10 point type, one point leaded. The words and terminology exempted are: (a) all words and terms defined in the forms, (b) all captions and subcaptions, (c) all tables and schedules, and (d) all medical terms. All exempted items are permitted in your state.

READABILITY SCORE

Name of Form	Form Number	Flesch Score
Application for Policy Change or Reinstatement	CFA3001PCR(02-12)	51.5

March 23, 2012
Date

Mark S. Wessel
Compliance Officer Policy Forms/Compliance

Statement of Variability
Form No. CFA3001PCR(02-12)

1. Company address.

We certify that any variability within these applications is limited to what is described above. Any change or modification outside of this Statement of Variability will be submitted for prior approval.

March 23, 2012

Dianne Harris
Compliance Analyst

Date